Department of Social Services

South Dakota Medicaid

Division of Medical Services (MS)

Division of Medical Services

Overview

- **What is Medicaid?**
- **Who We Serve**
- **Services Provided**
- **Medicaid Budget**

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South Dakota Medicaid:

- **Medicaid is the nation's publicly financed health care coverage program for low-income people enacted in 1965 under Title XIX of the Social Security Act and Title XXI the Children's Health Insurance Program (CHIP) enacted in 1997**

- **Medicaid is not Medicare**
  - Medicare is specific to the over 65 population and the disabled population who meet the federal disability criteria
  - Medicare is a federally administered and funded program

- **Medicaid is an entitlement program – all people eligible must be served**

- **Federal – State partnership governed by Medicaid State Plan**

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South Dakota Medicaid State Plan:

Is a contract between the state and the federal government describing how South Dakota administers the state's Medicaid program

- A contract with the federal government outlining who is served and what services are covered
- States administer the Medicaid program
- Each state plan is different due to optional services provided making it difficult to compare states side-by-side
- When you've seen one Medicaid program, you've seen one Medicaid program

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South Dakota Medicaid State Plan (cont.)

- Department of Social Services is the designated Single State Agency for overall administration
- Amendments to the State Plan reflect federal and state changes in the Medicaid program
- There is a formal process for making changes to the State Plan
  - An amendment must go through public notice and Tribal consultation prior to submission to the Regional Center for Medicare and Medicaid Services (CMS) for approval
- South Dakota State Plan can be found on the Department website at:
  - http://dss.sd.gov/medicalservices/medicaidstateplan/index.asp
- In addition, Medicaid Fee Schedules for Service (FFS) Reimbursement are maintained on the Department's website at:
  - http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx

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Regulatory Structure:

- **Federal Rules**
  - Code of Federal Regulations (CFR)
    - Defines the mandatory Medicaid benefits and populations that the state is required to provide health care coverage for to receive federal funding
    - Provides optional Medicaid benefits and populations a state can cover
- **State Rules**
  - Administrative Rules of South Dakota (ARSD)
    - Implements federal and state legislative mandates/changes
    - Contains specific limits on the amount, duration and scope of services for South Dakota Medicaid providers and recipients

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Medicaid Waivers:

- **States can only get waivers for specific areas of Medicaid**
- **Cannot waive the basic tenants of Medicaid**
  - Cannot cap enrollment
  - Must be cost/budget neutral
- **Can only vary from existing federal Medicaid requirements in certain areas, e.g.**
  - Level of care requirements i.e., serve people at home instead of institutions
  - Services or Populations Covered – usually used to expand services
- **Specific process to obtain waivers**
  - Requires a series of detailed steps, including an application and public notice
- **South Dakota has four Home and Community Based Waivers**
  - Provide services outside of institutions
    - DSS – aging and disabled waiver
    - DHS – 2 ID/DD waivers, 1 waiver for people with quadriplegia

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Who We Serve:

- **Provide Healthcare Coverage**
  - Low income children, pregnant women, adults and families
  - Elderly or disabled
  - Children in foster care
  - Adult coverage is limited to:
    - Elderly or disabled
    - Very low income families – 49% FPL (family of three $9,552 annual income)
  - 69% children and 31% adults
- **SFY 2013 Average Monthly Eligible South Dakotans**
  - Elderly – 7,021
  - Disabled – 18,400
  - Pregnant Women (pregnancy only) – 2,780
  - Low-income Adults – 11,420
  - Children of Low-income Families – 63,179
  - Children covered by CHIP – 13,328
  - **Total Average Monthly – 116,128**

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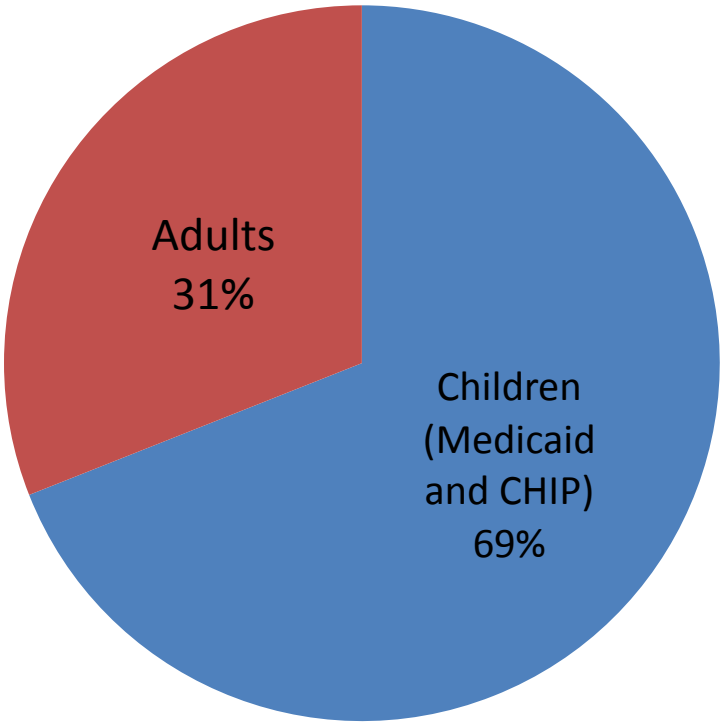
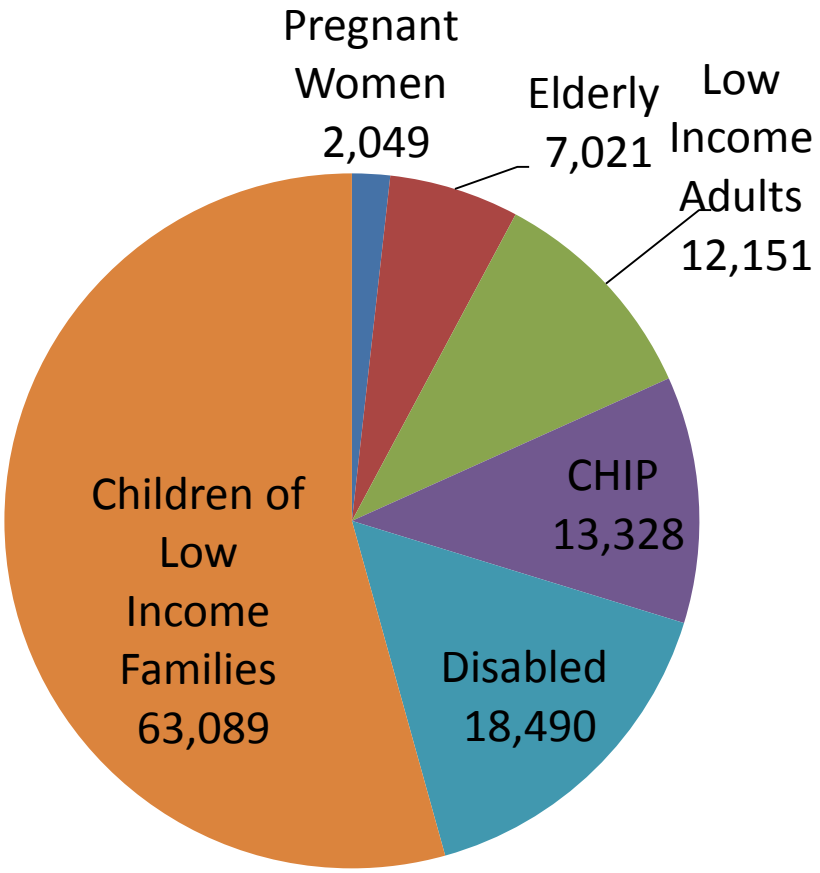
Medicaid Participation
Age
SFY 2013



Medicaid Participation
Eligibility Category
SFY 2013



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Medical Services - Average Cost of Service - SFY13:

		Avg. Eligibles
Aged	$1,944	7,021
Blind/Disabled Adults	$7,529	15,050
Blind/Disabled Children	$12,267	3,440
Children of Low Income Families	$2,331	63,089
Pregnant Women (Pregnancy Only)	$8,151	2,780
Low Income Adults	$5,843	11,420
Children's Health Insurance	$1,598	13,328
		116,128

* Does not include Medicare premiums, admin, drug rebates, & other non-direct service costs

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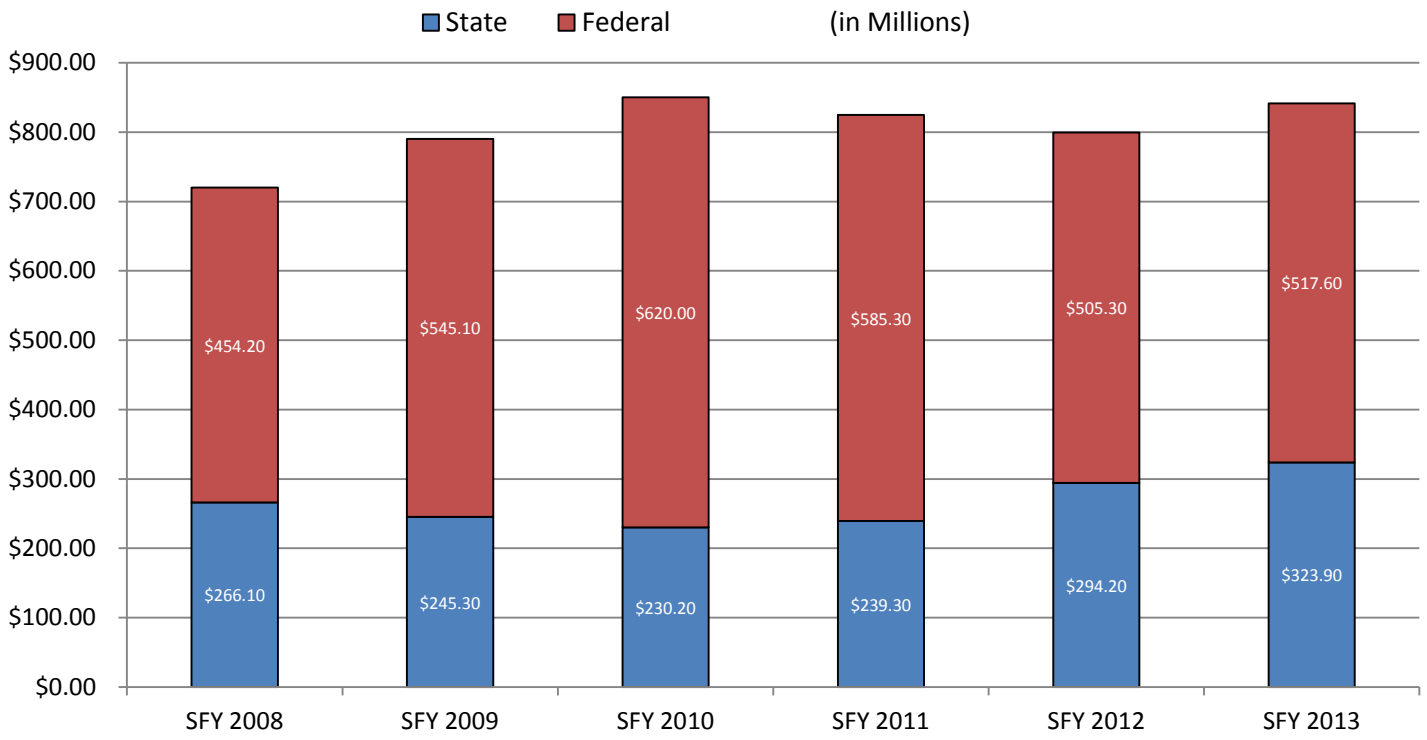
South Dakota Medicaid Expenditures, SFY 2008-2013



*Includes all state agency Medicaid expenditures

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Majority of Expenses by Provider Type, SFY 2013

Provider	SFY 2013 Expense (Millions)	% of Total
Hospital	$179.20	23.71%
Nursing Homes/Assisted Living Providers/Hospice	$146.00	19.32%
Community Support Providers	$111.50	14.75%
Physicians, Independent Practitioners and Clinics	$95.50	12.64%
Indian Health Services	$72.10	9.54%
South Dakota Developmental Center and Human Services Center	$32.60	4.31%
Pharmacies	$31.40	4.16%
Substance Abuse, Mental Health and Other Community Support Providers	$22.30	2.95%
Psychiatric Residential Youth Care Providers	$30.70	4.06%
Dentists	$17.30	2.29%
Durable Medical Equipment Providers	$ 9.80	1.30%
In-Home Service Providers for the Elderly and Skilled Home Health	$ 7.30	0.97%
Total for Majority of Expenses	**$755.70**	

*Includes all state agency Medicaid expenditures

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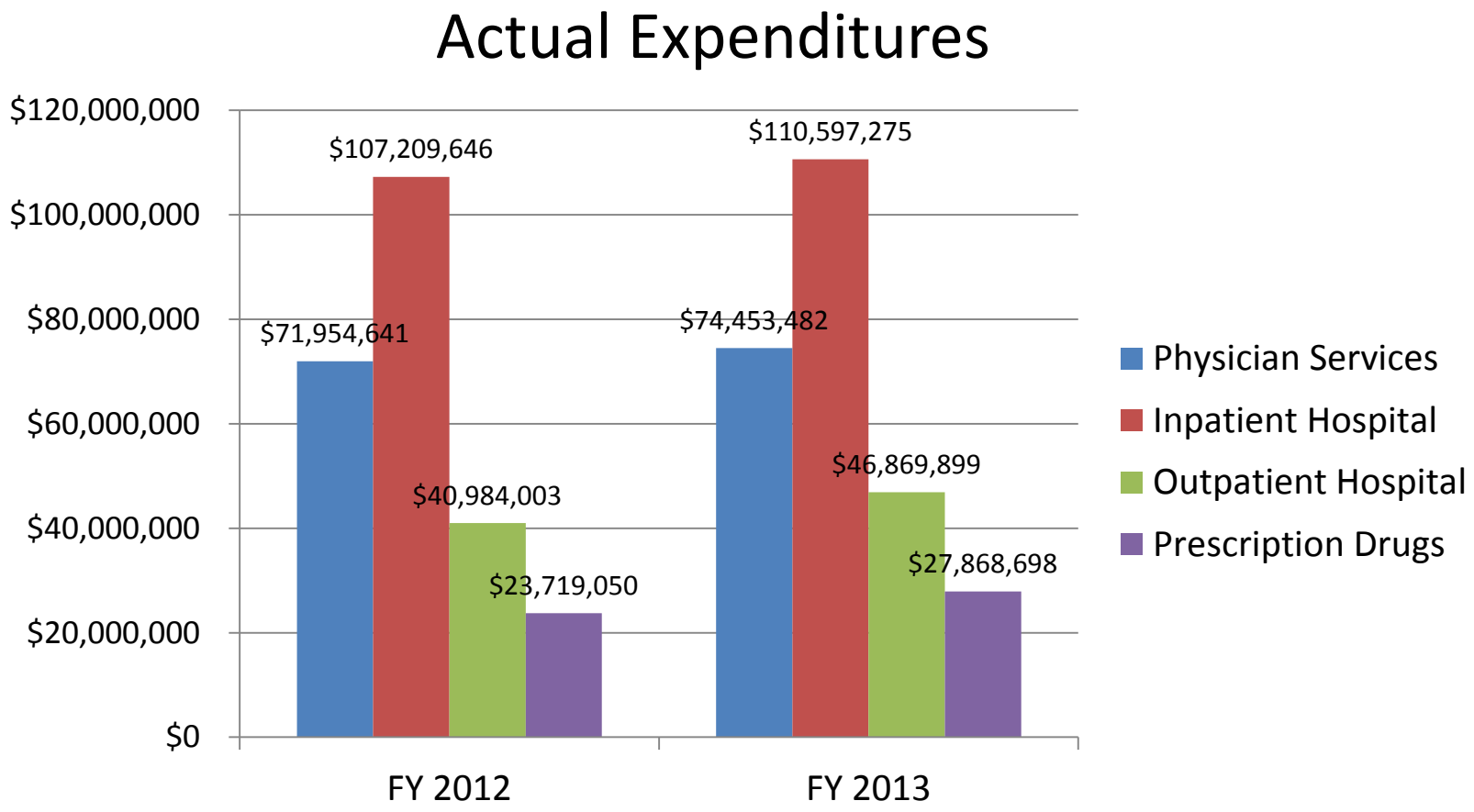
Health Care Services:

- **Certain health care services represent the largest share of our Medical Services budget. These are sometimes referred to as "The Big 4"**



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Health Care Services (cont.):

- **Physician Services**
  - Health care services provided by a Medicaid enrolled Physician or Advanced Practice Clinician
  - Provided in settings such as clinics and hospitals
- **Primary Care Case Management Services**
  - Designed to improve access, availability, and continuity of care by appropriately and effectively managing health care utilization
  - Primary Care Provider (PCP) is responsible for managing recipient's health care by directing all Managed Care designated services
    - Provides referrals for specific health care services
    - Provides 24 hour, 7 day a week access to medical care

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Health Care Services (cont.):

- **Inpatient Hospital**
  - Health care services furnished in a hospital under the direction of a physician that generally result in an overnight stay
  - Room and board as well as services received during hospitalization such as hospital-based physician services, nursing, diagnostic services and therapy
- **Outpatient Hospital**
  - Health care services provided in a hospital or clinic setting under the direction of a physician that do not result in an overnight stay
  - Includes laboratory, radiology, emergency room and outpatient surgical
- **Disproportionate Share Hospital Payments (DSH)**
  - Payments to qualifying hospitals that serve a disproportionate share of Medicaid and Medicare patients
  - FY13: $1,441,644 total payments to 19 hospitals

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Health Care Services (cont.):

- **Prescription Drugs**
  - Prescribed by a physician or other licensed Medicaid provider and dispensed by a licensed pharmacist
  - Pharmacy & Therapeutics Committee reviews utilization of all drugs and recommends clinical criteria for use of identified medications
  - High rate of generic drug utilization
    - SFY 2011 = 76.5%
    - SFY 2012 = 78.1%
    - SFY 2013 = 81.8%
    - SFY 2014 (5 months) = 82.6%
  - Drug Utilization Review Committee retrospectively reviews medication utilization for inappropriate use, over use, under use and drug/disease interactions, poly-pharmacy

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Health Care Services (cont.):

- **Durable Medical Equipment (DME)**
  - Provides equipment such as wheelchairs, prosthetics, and enteral and parenteral nutritional supplements and supplies
  - Equipment and supplies intended for repeated use and appropriate for use in the home
  - DME must be ordered by a physician with a certificate of medical necessity prior to Medicaid payment
  - Institutional settings are not allowed to submit separate claims for DME
- **Emergency Transportation**
  - Ambulance services
- **Non-Emergency Medical Transportation**
  - Reimbursement for transportation, lodging and meals
  - Travel must be for a covered Medicaid service

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Health Care Service – All Others

- **Adult Dental**
  - Diagnostic, preventive and restorative treatment for teeth and the oral cavity performed under the supervision of a dentist
    - Includes examinations, fillings, crowns, root canal therapy, and oral surgery
  - Delta Dental processes claims from non-IHS providers
    - Prior authorizations for certain dental services
  - Adult $1,000 limit for non-emergency dental services
- **Adult Optometric**
  - Replacement eyeglasses allowed every 15 months if medically necessary
- **Chiropractic Services**
  - Restricted to certain diagnoses – includes examinations, x-rays, and manipulations
- **Renal Disease**
  - Individuals must have physician verification of irreversible renal failure along with other requirements

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Other Medical Services:

- **Premium Assistance**
  - Assist Medicaid eligible individuals/families to pay for private health insurance so Medicaid is the payor of last resort
  - Average monthly qualified participants of 90 individuals/families
  - Cost effective program – SFY 2013 premium expenditures were $416,307 with a state general fund Medicaid healthcare claims savings of over $4 million.

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Other Medical Services (cont.):

- **Medicare Part A and Part B "Buy-In" program**
  - State Medicaid agency required to pay Medicare Part A and B premiums for individuals that qualify for both Medicare and Medicaid – known as dual eligibles
    - On average each month about 12,000 people are "dually eligible" and enrolled in both Medicaid and Medicare
  - Cost effective for the state as Medicare becomes primary insurance and Medicaid becomes secondary
- **Medicare Part D "Clawback"**
  - Began in 2006 when Medicare began providing prescription drug coverage for Medicare and Medicaid dual eligibles
  - State Medicaid agency required to make monthly payment to the federal government

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Other Medical Services (cont.):

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**
  - Includes services for children less than age 21on Medicaid
  - Federal requirement to cover screening and diagnostic services, and cover health care services needed by children, regardless of whether or not services are covered under the state's Medicaid plan
- **Children's Health Insurance Program (CHIP)**
  - Provides health coverage to children in families with incomes too high to qualify for Medicaid, but can't afford private coverage
  - South Dakota CHIP children are under the age of 19 with no health insurance and family income under 200% FPL
  - South Dakota's program is a Medicaid "look alike" program, meaning that CHIP covers the same services as Medicaid

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Other Medical Services (cont.):

- **Indian Health Services (IHS)**
  - Is the federal agency responsible for providing health care to American Indians
  - American Indians who are an enrolled member of a tribe can receive health care service at IHS facilities
  - IHS facilities included in the Aberdeen Area Service Unit include hospitals, health centers and a Tribally-Operated Health Service Site
  - American Indians who are also Medicaid eligible can receive health care services at IHS facilities and/or non-IHS facilities

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Other Medical Services (cont.):

- **American Indian health services funding**
  - IHS facilities are funded with 100% federal dollars for services they provide to American Indians and that are billed to Medicaid
  - Non-IHS facilities are funded at the Medicaid federal/state match FFP for the services they provide to Medicaid eligible American Indians
  - SFY 2013
    - 41,042 American Indians were on Medicaid every month representing 35.3% of all individuals eligible for Medicaid
    - In addition to IHS expenditures, $171.1 million dollars were paid at Medicaid's normal match rate for health care services provided outside IHS entities for American Indians in SFY13

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Medicaid Claims Payment - continued:

- **South Dakota Medicaid pays for medically necessary, covered health care services**

- **Meet or exceed federal timely payment requirements**

- **Medical Services Division staff process and adjudicate Medicaid claims**
  - SFY 2012 – Total claims processed = 4,664,960
  - SFY 2013 – Total claims processed = 4,844,728
    - 81% are submitted electronically

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Medicaid Program Integrity:

- **Third Party Liability**
  - Medicaid is the payer of last resort for health care services
  - Office of Recoveries and Fraud Investigations track and recover payments from third party sources such as other insurances
  - SFY 2013 – $8.3 million were recovered from third party sources
- **Internal and External Quality Assurance Review Processes**
  - **Internal**
    - Surveillance and Utilization Review Subsystem (SURS) Unit
    - MMIS claims edits
    - Prior authorization process
    - Hospital inpatient tracking
    - Provider enrollment procedures
  - **External**
    - Medicaid Fraud Control Unit (MFCU)
    - South Dakota Foundation for Medical Care

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Medicaid Program Integrity (cont.):

- **Federal Audits**
  - **Payment Error Rate Measurement (PERM) Audit**
    - Three year cycle – South Dakota consistently among lowest error rates in the country
      - 2011 PERM results lowest error rate out of 17 states
        - Claims processing = 1.2% error rate
        - Eligibility determination = 0% error rate
  - **Medicaid Integrity Contractors (MIC) Project**
    - Reviews provider claims and audits providers to identify overpayments and educates providers
  - **National Correct Coding Initiative (NCCI)**
    - CMS initiative to reduce and control improper Medicaid claims coding and payments
  - **Medicaid Recovery Audit Contractor (RAC) Program**
    - In-depth Federal audit of state Medicaid providers
    - CMS has twice exempted South Dakota from this requirement due to our state's low PERM error rates

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Affordable Care Act (ACA)Impact:

- **ACA has significantly impacted Medicaid programs**
- **Provider Enrollment**
    - Screening and validation of providers requesting enrollment
        - Federal database checks
    - Increased who has to enroll to include ordering, referring, and prescribing providers
    - Additional screening procedures required for “medium” and “high risk providers”
    - Requires revalidation a minimum of once every five (5) years
- **Electronic Health Records**

•A federal program established under the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of electronic health records by heath care providers

2016 is the last year for health care providers to attest for EHR incentive payments
Meaningful use and provider eligibility is defined federally

•Incentive payments are 100% federal dollars

SFY 2013 total $14,248,609

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ACA Impact - continued:

- **Primary Care Provider (PCP) Enhanced Rate**
  - Enhanced reimbursement to eligible PCPs between 1/1/2013 and 12/31/2014
    - Limited to certain PCPs and certain procedures
    - The enhanced payment is 100% federally funded
    - Total of $6,695,723 PCP payments between 1/1/2013 to 12/31/2013

- **HIPAA 5010 Operating rules**
  - Specific criteria for electronic exchange of information between health payers and providers.
  - 3 step phased implementation will be complete in 2016
    - Still waiting for operational rules from CMS

- **ICD 10- Internal Classification of Diseases**
  - Used for diagnosis by providers and included on claims for payment Approximate Number of Codes increasing from 18,000 to 140,000
  - Effective 10/1/2014

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South Dakota Medicaid Initiatives:

- **Health Homes**
  - Established by the Affordable Care Act
  - Recommended by the Medicaid Solutions Workgroup
  - Provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses
  - Intent is to increase health outcomes and reduce costs related to uncoordinated care
- **Money Follows the Person**
  - Authorized by Congress in the Deficit Reduction Act of 2005
  - Designed to assist states to balance long-term care systems
  - Assist to transition Medicaid recipients from institutions to the community

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South Dakota Medicaid Initiatives- con't:

- **Inpatient Hospitalization 6-day Tracking**
  - Acute care hospitals report to Medical Services staff nurses on day 6 of an inpatient hospitalization
  - Each case is reviewed for medical necessity and the most conservative level of care
  - Provide assistance with placement as needed
- **Out-of-State Hospitalization Prior Authorization**
  - Out-of-state inpatient hospitalizations outside a 50 mile radius of the South Dakota border requires a prior authorization
  - Ensure care is provided in South Dakota in the most conservative location when available
  - Eliminates unnecessary transportation, food and lodging expenses

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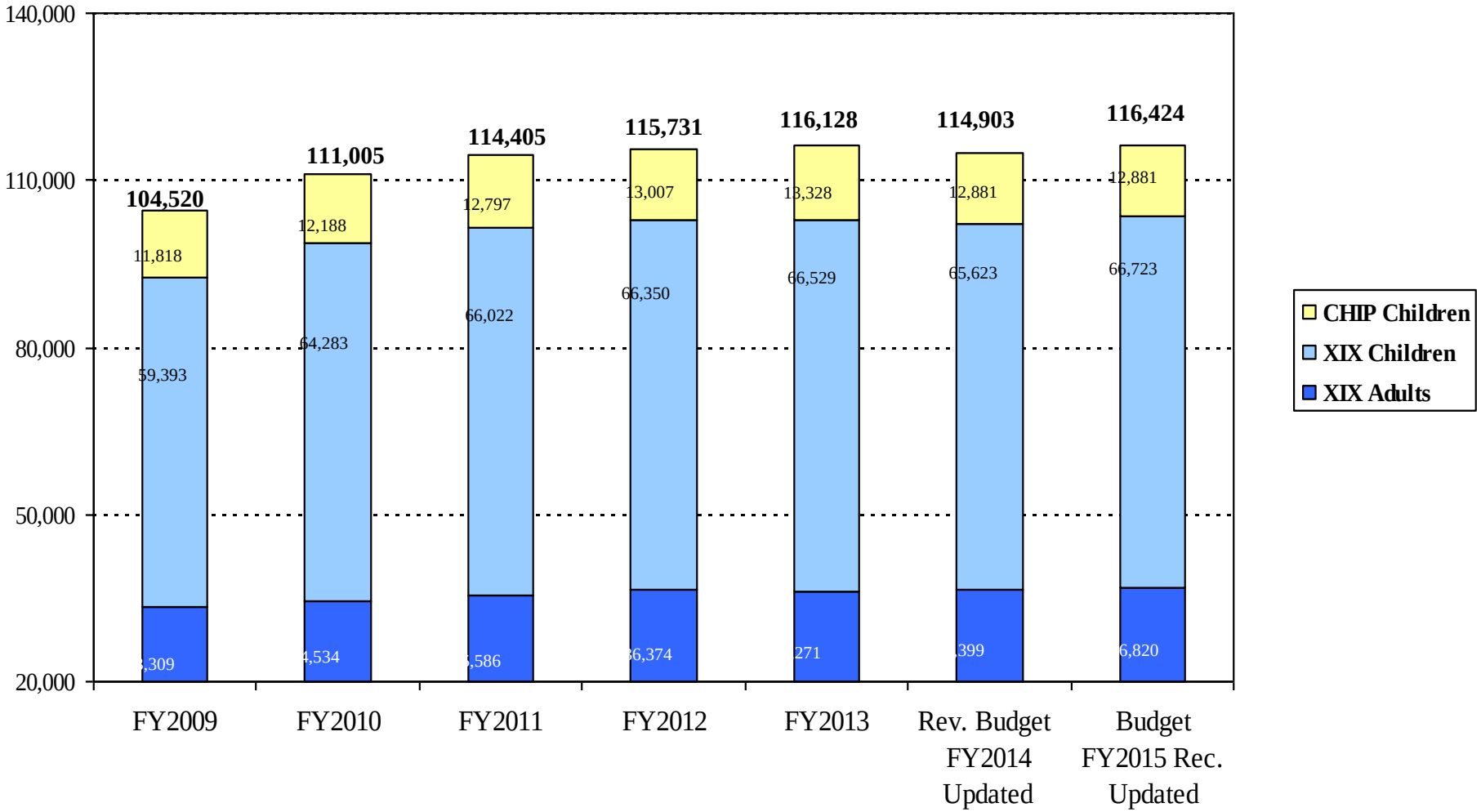
Medicaid Ave. Monthly Eligible Totals Revised January Data



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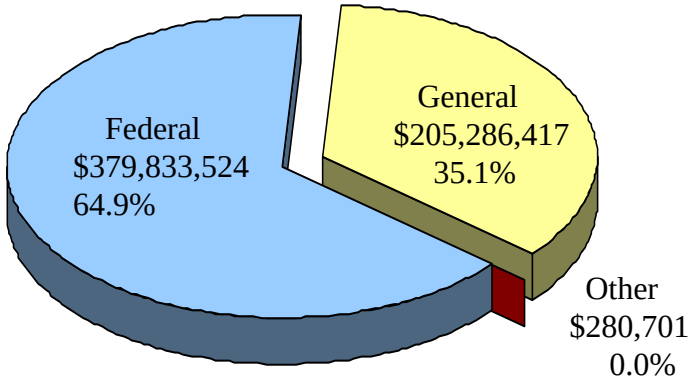
FY14 Operating Budget: (Does not include General Bill Amendments)



Total: $585,400,642 and 51.0 FTE

FY14 Major Budget Areas:

	FTE	General	Federal	Other	Total
MS Administration and Field Staff	51.0	$4,464,001	$36,238,585	$280,701	$40,983,287
Physician Services	0.0	$36,145,596	$46,283,348	$0	$82,428,944
Inpatient Hospital	0.0	$56,702,900	$67,102,565	$0	$123,805,465
Outpatient Hospital	0.0	$21,969,047	$25,998,307	$0	$47,967,354
Prescription Drugs	0.0	$13,244,540	$14,549,431	$0	$27,793,971
Other Medical Services	0.0	$7,152,868	$8,464,754	$0	$15,617,622
Medicare Part A, B, D, and Crossovers	0.0	$41,970,155	$30,916,203	$0	$72,886,358
Early and Periodic Screening, Diagnosis, Treatment (EPSDT) Services	0.0	$12,942,344	$14,057,581	$0	$26,999,925
Children's Health Insurance Program (CHIP)	0.0	$7,873,061	$16,684,205	$0	$24,557,266
Indian Health Services	0.0	$0	$84,577,751	$0	$84,577,751
Health Information Technology	0.0	$0	$31,700,000	$0	$31,700,000
All Others	0.0	$2,821,905	$3,260,794	$0	$6,082,699
Total Medical Services	**51.0**	**$205,286,417**	**$379,833,524**	**$280,701**	**$585,400,642**
Personal Services	51.0	$697,074	$2,236,008	$0	$2,933,082
Operating Expense	0.0	$204,589,343	$377,597,516	$280,701	$582,467,560
Total Medical Services	**51.0**	**$205,286,417**	**$379,833,524**	**$280,701**	**$585,400,642**